THE COMMONWEALTH OF MASSACHUSETTS

State Board of Retirement

ONE ASHBURTON PLACE, BOSTON, MA 02108-1607

NEW MEMBER ENROLLMENT FORM

SECTION A To be filled out by employee *(Please print or type, except for signature).*

1

Name _____ Maiden Name _____ S.S.N. _____

Street Address _____ D.O.B. ____/____/____ Sex ❑ M ❑ F

City _____ , State ____ , Zip Code _____ Phone # (____) _____

Marital Status

❑ Married ❑ Single ❑ Widowed ❑ Divorced

Spouse D.O.B ____/____/____

Number of Children ☐

Are you a Veteran?

❑ Yes ❑ No

Dates of Military Service _____

A COPY OF A MILITARY DISCHARGE MAY BE REQUESTED

Position _____

Start Date _____

Agency or Department _____

Agency Phone # (____) _____

The retirement law establishes specific periods of active service, which may qualify you for certain Veteran benefits.

2 Past membership history with any other contributory retirement system in Massachusetts.

RETIREMENT SYSTEM	FROM	TO	WAS REFUND TAKEN?	
			❑ YES	❑ NO
			❑ YES	❑ NO
			❑ YES	❑ NO
			❑ YES	❑ NO

3 Are you currently or have you ever received a retirement allowance from another public retirement system? ❑ YES ❑ NO

4 Statement and Signature By Member

I certify the above information to be true and correct to the best of my knowledge and hereby accept membership in the Massachusetts State Retirement System. This statement is signed under penalties of perjury.

_____ (Date) _____ (Signature)

(continues on reverse)

Please return completed form (Section A—questions 1–5) to:
State Board of Retirement, One Ashburton Place – Room 1219, Boston, MA 02108-1607

Section B—question 6 (on reverse) to be completed by the Agency.

SECTION A *(Continued)*

5 Beneficiary Information

Beneficiary or beneficiaries nominated will receive in the proportion designated any sum due at your death.

The right to change any nominated beneficiary is reserved by the member.

A BENEFICIARY BLANK WITH CORRECTIONS OR ERASURES IS NOT ACCEPTABLE

GIVE COMPLETE NAME AND ADDRESS OF EACH BENEFICIARY			
Name:	**Designation:**	**Proportion:***	Date of Birth:
Street:	❑ Primary	❑ All	Relationship:
City, State, ZIP:	❑ Contingent	❑ ________ % (Percent)	Beneficiary Social Security #:
Name:	**Designation:**	**Proportion:***	Date of Birth:
Street:	❑ Primary	❑ All	Relationship:
City, State, ZIP:	❑ Contingent	❑ ________ % (Percent)	Beneficiary Social Security #:
Name:	**Designation:**	**Proportion:***	Date of Birth:
Street:	❑ Primary	❑ All	Relationship:
City, State, ZIP:	❑ Contingent	❑ ________ % (Percent)	Beneficiary Social Security #:
Name:	**Designation:**	**Proportion:***	Date of Birth:
Street:	❑ Primary	❑ All	Relationship:
City, State, ZIP:	❑ Contingent	❑ ________ % (Percent)	Beneficiary Social Security #:
Name:	**Designation:**	**Proportion:***	Date of Birth:
Street:	❑ Primary	❑ All	Relationship:
City, State, ZIP:	❑ Contingent	❑ ________ % (Percent)	Beneficiary Social Security #:

_______________________ (Date)

_______________________ (Signature)

_______________________ (Signature of Witness)

***Must Total 100% — If Contingent Please Specify**

(A CHANGE IF BENEFICIARY FORM must be used if you wish to change your designated beneficiary/beneficiaries. You may obtain this form from your payroll department or from the Board of Retirement)

SECTION B To be completed by the Agency:

6

POSITION		DEDUCTION	SERVICE STATUS
		❑ 5%	❑ Full-Time
		❑ 7%	❑ Part-Time ________%
Start Date ________		❑ 8%	❑ Temp/Sub:
Start Date ________		❑ 9%	
STATE POLICE Start Date ________		❑ 12%	
Date of First Deduction ________	❑ New ❑ Transfer	❑ 30 Plus	❑ Other

_______________________ (Agency Name and Payroll Number)

_______________________ (Authorized Signature)